Special Considerations for Behavioral Treatment Providers Regarding the Coordination of Benefits Process

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Objective

To provide information and specific scenarios to behavioral treatment providers regarding the coordination of benefits (COB) process and submitting prior authorization (PA) requests and claims for members with commercial health insurance.

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Training Prerequisites

- This training assumes behavioral treatment providers have basic knowledge of the ForwardHealth COB processes.
- Providers should review the Overview of ForwardHealth Coordination of Benefits and the Commercial Insurance Process webcast for basic COB concepts prior to viewing this training.
- Providers can access recorded trainings from the Training page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/content/provider/training/TrainingHome.htm.spage.

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Agenda — Part 1

- Key Concepts of Behavioral Treatment Claims and Prior Authorization Requests
  - Behavioral treatment services
  - Available code sets
  - ForwardHealth-covered procedure codes
  - Modifiers
  - Appropriate procedure codes to use when commercial health insurance is the primary insurance

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Agenda — Part 2

- The Coordination of Benefits Process Specific to Behavioral Treatment Services
  - COB process
  - Provider considerations
  - Behavioral treatment-specific COB scenarios
  - Considerations for behavioral treatment providers
  - Impacts on reimbursement

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Agenda — Part 3

- Other Coordination of Benefits Processes to Consider
  - Provider-based billing
  - When commercial health insurance codes do not match ForwardHealth procedure codes
  - Resources

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Part 1 — Key Concepts of Behavioral Treatment Claims and Prior Authorization Requests

Behavioral Treatment Services

- The ForwardHealth behavioral treatment benefit covers services designed specifically for adaptive behavior assessment and treatment.
- Treatment may be authorized for members with autism or other diagnoses or conditions associated with deficient adaptive or maladaptive behaviors.

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Available Code Sets

- There are multiple procedure code sets and modifiers used within the health insurance industry to indicate behavioral treatment services on claims.
- ForwardHealth has chosen to use the following *Current Procedural Terminology* (CPT) category III procedure code sets and three specific modifiers for behavioral treatment services.

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ForwardHealth-Covered Procedure Codes

- ForwardHealth covers the following CPT procedure codes for behavioral treatment services:
  - 0359T (Behavior identification assessment)
  - 0360T and 0361T (Observational behavioral follow-up assessment)
  - 0364T and 0365T (Adaptive behavior treatment by protocol)
  - 0368T and 0369T (Adaptive behavior treatment with protocol modification)
  - 0370T (Family adaptive behavior treatment guidance)

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Modifiers

ForwardHealth uses the following modifiers for behavioral treatment services.

Modifier	Description	Notes
AM	Physician, team member service	Use with code 0370T when documentation supports that a team meeting was performed. This modifier is used in addition to modifiers TG or TF based on the level of service provided.
TG	Comprehensive level of service	Benefit covers high-intensity, early intervention comprehensive behavioral treatment.
TF	Focused level of service	Benefit covers time-limited lower-intensity treatment that focuses on specific behaviors or deficits.

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Procedure Codes to Use When Commercial Health Insurance Is Primary Payer

- ForwardHealth recognizes the following codes, which are commonly used by commercial health insurance companies for behavioral treatment services, in addition to the ForwardHealth-allowable codes, when billed with the processing results of the commercial health insurance company:
  - 90791 (Psychiatric diagnostic evaluation)
  - 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes)

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Procedure Codes to Use When Commercial Health Insurance Is Primary Payer (Cont.)

- H0031 (Mental health assessment, by non-physician)
- H0032 (Mental health service plan development by non-physician)
- H2012 (Behavioral health day treatment, per hour)
- H2019 (Therapeutic behavioral services, per 15 minutes)

- When coordinating commercial health insurance and ForwardHealth benefits, providers are required to first bill the commercial health insurance plan **according to the commercial insurer's policies** and designated procedure codes, modifiers, and units.

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Part 2 — The Coordination of Benefits Process Specific to Behavioral Treatment Services

Coordination of Benefits Process

Providers should complete the following steps:

1. Verify if the member has other health insurance coverage, and report other insurance coverage discrepancies.
2. Bill the other health insurance carrier(s):
   - Exhaust other commercial health insurance sources.
   - Review outputs of other insurance processing (Remittance Advice).

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Coordination of Benefits Process (Cont.)

3. Submit the claim to ForwardHealth using one of the following methods:
   - An electronic submission containing claim adjustment reason and remark code(s) and/or payment information.
   - A paper claim and the Explanation of Medical Benefits form, F-01234, containing other insurance indicator(s), claim adjustment reason and remark code(s), and/or payment information.

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Provider Considerations

- Providers should consider the following when a member has coverage from both commercial health insurance and ForwardHealth:
  - Any PA request implications, including which code set(s) to use
  - Any claim considerations, including which code set to use and applicable effective dates

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Behavioral Treatment-Specific Coordination of Benefits Scenarios

- Scenario 1 – The member has commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are covered by both entities.
- Scenario 2 – The member has commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are covered by both entities; however, commercial health insurance has been exhausted during the plan year.
- Scenario 3 – The member has commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are not covered by the member's commercial health insurance.

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Scenario 1

- A member has commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are covered by both entities.
- PA request requirements
  - Providers should submit a PA request to ForwardHealth even when services are covered by commercial health insurance.
  - Providers are required to use the procedure codes, modifiers, and units associated with the member's commercial health insurance on the Prior Authorization Request Form (PA/RF), F-11018, submitted to ForwardHealth.

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Scenario 1: Claims Submission

- Providers should bill the commercial health insurer using the commercial insurance policies, procedure codes, modifiers, and units.
- Once the commercial health insurer has processed a correct and complete claim, providers should:
  1. Submit a claim to ForwardHealth with the same procedure codes, modifiers, and units as billed to the commercial health insurer.
  2. Use the claim adjustment reason and remark code(s) and payment information received from the commercial health insurer to indicate the commercial health insurance billing outcome.

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Scenario 1: Claims Submission (Cont.)

Note: Providers should report the reason and remark code(s) at the level provided by the commercial health insurer (either the header or detail level).

- When submitting claims on the Portal, providers should complete the:
  - Other Insurance Header Information tab
  - Other Insurance Detail Information tab
  - Other Insurance EOB (Explanation of Benefits) Information tab
- Refer to the Claims User Guide for more detailed information.

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Scenario 1: Claims Submission (Cont.)

- When submitting claims via the Provider Electronic Solutions (PES) software, providers should:
  - Use the Other Insurance tab.
  - Report other insurance payment information at the header level, and complete the OI Adj tab.
  - Report other insurance payment information at the detail level, and complete the Srv Adj tab.
    - Enter reason and/or remark code(s) at the header or detail level, provided by the commercial health insurer.
    - Refer to the PES manual on the Portal for more information.

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Scenario 1: Claims Submission (Cont.)

- When submitting claims via 837 Health Care Claim: Professional (837P) transactions, providers should:
  - Enter the reason and/or remark code(s) on the claim.
  - Refer to the 837P companion guide in the Trading Partner area of the Portal for more information.
- When submitting paper claims, providers should complete all sections of the Explanation of Medical Benefits form to report commercial health insurance information and submit it along with the claim.

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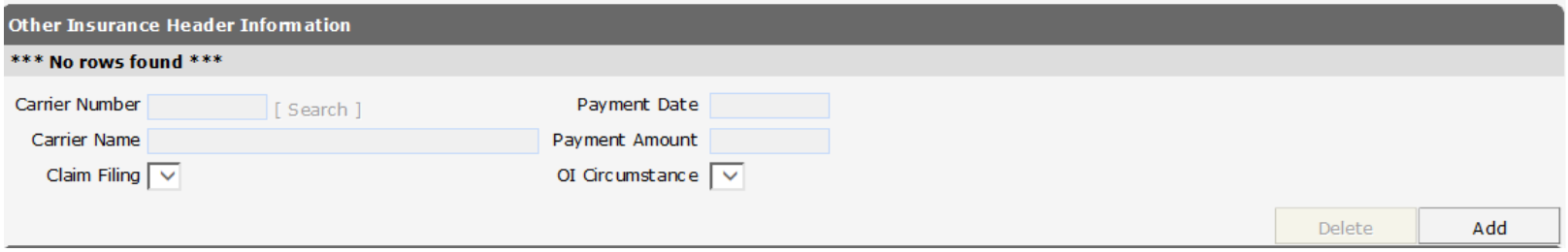
Scenario 1: Portal Other Insurance Header Information



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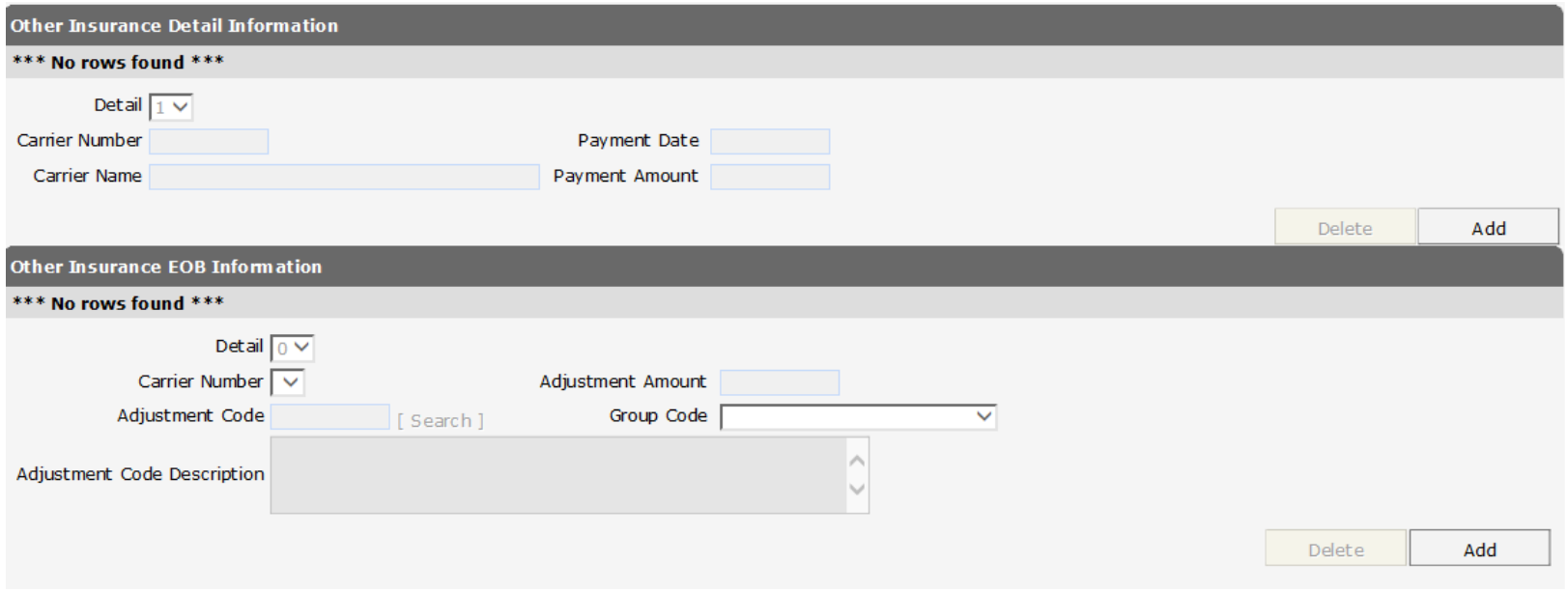
Scenario 1: Portal – Other Insurance Detail and EOB information



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Scenario 2

- The member has commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are covered by both entities; however, commercial health insurance benefits have been exhausted during the plan year.
- Providers should complete the following steps in this scenario:
  1. Complete the steps for PA requests and claims submission as described in Scenario 1.

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Scenario 2 (Cont.)

2. Once the member's commercial health insurance benefits have been exhausted for the **plan year**, amend the PA request to reflect the following:
   - ForwardHealth procedure codes
   - The requested remaining units for the plan year
   - A specific requested start date for the amendment
3. Once the PA amendment request is approved, submit claims with the following:
   - Dates of service that are within the amendment-approved dates
   - ForwardHealth procedure codes

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Scenario 2 (Cont.)

- Providers should indicate other insurance information on the following claim types as follows:
  - Portal: Indicate Y.
  - PES: Indicate OI-Y under the OI tab.
  - 837P: Refer to the 837P Companion Guide for the OI-Y equivalent.
  - Paper: Indicate "Y" in Element 11 of Section IV (Paid/Deny) of the Explanation of Medical Benefits form.

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Scenario 2 (Cont.)

- When a new plan year begins, providers should:
  - Amend the current approved PA or end date the current PA.
  - Follow the instructions in scenario 1 to request a new PA.

***Note*:** Plan years are specific to each commercial health insurance policy and do not necessarily run from January through December.

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Scenario 3

- The member has both commercial health insurance and is covered under ForwardHealth. Behavioral treatment services are not covered by the member's commercial health insurance.
- Once providers have verified that commercial insurance does not cover behavioral treatment services, they should follow these steps:
  1. Document any denials by the commercial health insurer for noncovered services; maintain this documentation in the member's record.

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Scenario 3 (Cont.)

2. If the commercial health insurer has not provided written documentation of denial of noncovered services, document how a lack of coverage was verified (e.g., be referring to a copy of the member's policy).

Note: Documentation of noncovered services must be verified at least once per **benefit plan year**, as polices can change.

- Providers are required to submit PA requests and claims using ForwardHealth procedure codes.

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Scenario 3 (Cont.)

- Providers should not submit documentation of commercial insurance denial, unless requested.
- Providers should submit claims to ForwardHealth with the other commercial health insurance information (e.g., OI-Y).

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Impact on Reimbursement

- For each service submitted on a claim, ForwardHealth calculates an allowed amount based on the ForwardHealth-established maximum allowable fee and units of service provided.
- The ForwardHealth-allowed amount for covered services is considered payment in full by ForwardHealth.

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Impact on Reimbursement (Cont.)

- Providers are reimbursed at the lesser of their billed amount and the ForwardHealth allowed amount for the service, minus any other insurance payment.
- Stated another way, if the other insurance payments exceed the ForwardHealth allowed amount, no further payment will be made by ForwardHealth.

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Impact on Reimbursement (Cont.)

Examples

Reimbursement Examples for Other Insurance Payments			
Explanation	**Example**		
	1: H0031	**2: H2012**	**3: H2019**
Provider's billed amount	$50	$40	$8
Other insurance paid	$30	$5	$4
ForwardHealth maximum allowable fee *Note:* Amounts listed are not actual max fee amounts	$10	$10	$10
Medicaid payment	$0	$5	$4

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Part 3 — Other Coordination of Benefits Processes to Consider

Provider-Based Billing

- A provider-based billing claim is an invoice sent to a provider by ForwardHealth when ForwardHealth becomes aware of commercial insurance that may cover the services and ForwardHealth has already made a payment.
- The provider-based billing claim invoice will contain the original codes billed to ForwardHealth.

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Provider-Based Billing (Cont.)

- The provider may need to change codes to match the commercial insurance policies prior to billing the commercial insurance.
- For more detailed information on provider-based billing, refer to the Provider-Based Billing chapter of the Coordination of Benefits section of the ForwardHealth Online Handbook.

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Provider-Based Billing (Cont.)

Example

- Provider receives a Provider-Based Billing Summary letter for claims previously paid by ForwardHealth with CPT code 0359T–0370T with modifiers. The provider should take these steps:
  1. Verify behavioral treatment coverage and allowable procedure codes with commercial insurance. Commercial insurance may only allow one code or different codes. Refer to the commercial insurance's allowable procedure codes for behavioral treatment.

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Provider-Based Billing (Cont.)

2. Produce a claim and submit it to commercial insurance according to the commercial insurer's policies (i.e., using the commercial insurer's procedure and modifier codes).
3. Receive response from commercial insurance.
4. Do one of the following:
   - **Within 120 days** — Respond to the ForwardHealth provider-based billing unit using the address on the Provider-Based Billing Summary letter.
   - **After 120 days** — Submit a new claim (recoupment has been established).

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When Commercial Health Insurance Codes Do Not Match ForwardHealth Procedure Codes

- ForwardHealth does not use billing crosswalks between commercial health insurance procedure codes and ForwardHealth's allowable procedure codes.
- Coordination of benefits claims are reimbursed using this fee schedule.
- ForwardHealth assigns a fee to each commercial procedure code in the maximum allowable fee schedule for behavioral treatment.

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Resources

- Online Handbook at www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx
- New Behavioral Treatment Benefit page on the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/content/HTML/BTB/Behavioral_Treatment_Benefit.htm.spage
- Overview of ForwardHealth Coordination of Benefits and the Commercial Insurance Process training from the ForwardHealth Provider Training page at www.forwardhealth.wi.gov/WIPortal/content/provider/training/COB/Home.htm.spage

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Resources (Cont.)

- Companion guides at *www.forwardhealth.wi.gov/WIPortal/Subsystem/Account/StaticHTML.aspx?srcUrl=CompanionDocuments.htm*
- Provider Services at 800-947-9627
- Electronic Data Interchange Helpdesk at 866-416-4979
- Portal Helpdesk at 866-908-1363
- Professional Relations representatives

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Questions

- Behavioral treatment providers may submit questions related to coordinating the ForwardHealth benefit with the member's commercial insurance via email to DHSBTCOB@wi.gov.
- Some inquiries may require research; additional time for responses may be required.

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Thank You